Community Providers Association
Caring for Connecticut.

TO: Members, Human Services Committee
FROM: Sheila B. Amdur, Interim President/CEO
CT Community Providers Association
RE: **Raised Bill No. 1026: An Act Concerning an Adequate Provider Network to Ensure Positive Health Outcomes for Low Income Residents**
DATE: March 5, 2013

CCPA today joins other provider groups to support this legislation that addresses the provider network that will be needed when health care coverage under the Affordable Care Act expands to 170,000 to 200,000 people, including approximately 50,000 new Medicaid enrollees. It is also estimated that approximately the same number will not have coverage.

At the same time as this major expansion occurs, the Governor's proposed budget recommends deep cuts to all sectors of health care providers under the Medicaid program. On the behavioral health side, $9 million cuts are recommended in behavioral health spending over two years, and the Governor's budget recommends eliminating all grants for Medicaid reimbursable services. Hospitals will be confronted with reducing or eliminating services that are "loss leaders", which will directly threaten the inpatient and outpatient behavioral health services they provide. Nonprofit providers will have to sharply curtail or eliminate their outpatient mental health and substance abuse treatment services.

Although the state will realize a windfall of over $250 million as the LIA program becomes fully paid for by the federal government, the state is also making deep cuts in its Medicaid program and has not addressed in any way what the access issues will be for new enrollees to Medicaid, let alone existing clients who will be losing services. Mercer in a report commissioned by OPM indicated that the Medicaid expansion to 138% FPL will place additional strain on Connecticut Medicaid provider networks. They recommended that "an analysis of the Connecticut Medicaid provider infrastructure should be undertaken to assess the impact of expanding the Medicaid eligible population as required by the PPACA."

No such analysis has taken place, nor has any analysis taken place that would address improving health outcomes and address racial and ethnic disparities, of particular concern in the populations served by Medicaid. This legislation addresses studying the obstacles to "achieving an adequate health care provider network for Medicaid recipients" and also the strategies needed to improve access and health outcomes. What we do know is that the Medicaid population has higher costs of care than commercially insured populations so that the

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viability of the costs of providing health care over time must address better outcomes.

This legislation also addresses alignment with the Administration's Office of Health Care Reform and Innovation, which just received a federal grant to primarily address alignment of Medicaid with commercial insurers, and only tangentially addresses access. The legislation also proposes seeking foundation or other funding to support the costs of the study. We believe the state is "flying blind" at this point in terms of what we will confront when the potentially 200,000 people who will now have health care insurance will be seeking care, and frankly, how this may further compress or shrink Medicaid access due to its low rates.

We urge your support of the legislation.

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91 Northwest Drive | Plainville, CT 06062 | 860-793-3500
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March 4, 2013

Dear

I am writing to ask you to restore funds to the Department of Mental Health and Addiction budget for all levels of care that are Medicaid reimbursable to include mental health and substance abuse intensive outpatient and outpatient levels of care. The grants to nonprofit providers like Wheeler Clinic would be eliminated leaving a devastated provider system and thousands of highly vulnerable people without any option for care. Elimination of these state grants would immediately reduce Wheeler's state funding for these services by close to $750,000. Medicaid reimbursement only covers less than half of our current cost of care and there are significant barriers and fallacies related to how the Exchange will impact some of our most vulnerable citizens.

On an ongoing basis, Wheeler enrolls over 1,700 individuals in our DMHAS-funded outpatient programs in the central Connecticut and Hartford regions. Our Hartford adult office admits over 100 new individuals each month. Eighty percent of the adults we serve are on Medicaid or uninsured. They come to us with multiple stressors including mental health and substances abuse issues, involvement in the child welfare and/or community justice systems, sometimes suicidal or at risk of hospitalization and may present a safety risk to children and others in the community. Loss of this funding would result in an immediate, significant reduction in access to care for these populations. Our organization cannot sustain these services at this point in time or shortly after January 1, 2014 without the grants.

We fully understand the need to reform the financing models in our fragile healthcare system and support the reforms within the Affordable Care Act. The ***timing*** of the change is critical to the survival of the healthcare system and the behavioral health safety net in Connecticut. Dramatic cuts to grants that occur ***too soon will plunge providers over a cliff with no hope of recovery or survival. It is critically important to note and review the information that has been presented to the administration.***

Medicaid Expansion will strain provider networks (From Mercer's final report to the administration)

- According to a report commissioned by OPM, Medicaid expansion to 138% FPL, is estimated to increase Medicaid/CHIP enrollment by almost 100,000 in 2014, when the Exchange goes live. This enrollment expansion will place additional strain on Connecticut Medicaid provider networks, and increase cost shifting to commercial carriers. They recommended that "an analysis of the Connecticut Medicaid provider infrastructure should be undertaken to assess the impact of expanding the Medicaid eligible population as required by the PPACA." It is not clear that this has been done. Nonetheless, OPM pushes for cuts to state grants.

- Retrospective Income Adjustment - the income that an enrollee "enters" the Exchange with, on which the subsidy is based, may decrease/increase during the year. The enrollee will bear ALL of the risk meaning that s/he will be responsible for fluctuations in cost sharing (they will owe the state money they don't have), thereby increasing the possibility that they will drop out of the Exchange and return to a decimated provider network due to the elimination of significant grant funding that has been removed abruptly, prematurely and permanently.

- The Exchange will be too costly for many previously uninsured - even with subsidies, the cost of paying the premium net of subsidies and the associated cost sharing will consume a substantial portion of their household income (page 37 of the Mercer Report)

- Massachusetts passed groundbreaking health care legislation in 2006. It has taken **more than 6 years** for the establishment of a framework and infrastructure for reaching the existing number of enrollees. Eliminating the DMHAS state grants concurrent with launch of the Exchange allows no time for individuals to purchase coverage and for enrollment to build. Providers will have no source of payment for thousands of individuals in a system that currently reimburses below cost.

- In Massachusetts, The Connector has been an active purchaser - actively imposing requirements and limitations on insurers and despite its high level of enrollment, it continues to provide financial support to its low-income enrollees to help ensure coverage continues to be affordable for them in Massachusetts. There is no indication that Connecticut will utilize any of these strategies to encourage and sustain levels of enrollment in the Exchange that would justify the elimination of grant funding to organizations needed to provide services during a period of transition.

Please restore DMHAS funding for outpatient grants and all Medicaid funded programs and only make the grant reductions once the care of eligible individuals is determined to be accessible and stable in a adequately funded provider network. Conduct a cost analysis of behavioral health outpatient service provision and ascertain what rates are needed to allow access to mental health and substance abuse treatment for those in need. Providers should be allowed to inform these discussions.

Sincerely,

Susan Walkama

Susan Walkama, LCSW
President and CEO